Report to the Legislature

Community Options Program

Community Options Program Waiver

Calendar Year 2003

Department of Health and Family Services
Division of Disability and Elder Services
Bureau of Aging and Long Term Care Resources

Executive Summary

The Community Options Program (COP) began with the passage of the 1981 state budget. The purpose of the program was to create a home and community-based alternative to nursing home care. Wisconsin had a high use of nursing homes, with dramatic annual increases in nursing home spending. The Community Options Program was intended to offer more choices for older people and people with disabilities at a lower cost to the state. In 1986, Wisconsin received a federal Medicaid Home and Community-Based Waiver for people who are elderly or have a physical disability, which allowed the state to get federal matching funds for COP with some flexibility in how it would meet the Title 19 (Medicaid) requirements. The Community Options Program serves a limited number of people and is not an entitlement.

The Community Options Program General Purpose Revenue (GPR) serves people who are elderly or who have a physical, developmental or mental disability. The COP Medicaid waiver serves only people who are elderly or have a physical disability. This includes the Community Options Program-Waiver (COP-W) and the Community Integration Program II (CIP II). Three other waivers serve people with developmental disabilities.

In 2003, the state and federal government spent $196,712,745 on the Community Options Program and the Community Options Program waivers administered by all counties and one tribe. This is equal to about 41 percent of the total spending on all home and community-based waiver programs (Appendix B). Waivers for people with developmental disabilities spent $281,866,733 in 2003.

Individuals who use waiver services are also eligible for the Medicaid card benefits, and must use the Medicaid card before relying on the waivers to fill gaps in care. Participants in CIP II and COP-W used $126,203,757 in benefits from their Medicaid card. The largest expenditures were for prescription drugs ($45 million) and personal care ($34 million).

The *average* daily cost of care for participants in CIP II and COP-W in Calendar Year (CY) 2003 was $77.03. This includes state and federal funds totaling $295.8 million per year. The *average* daily cost of care for people in nursing homes, at the same combination of levels of care, was $99.14 of Medicaid funds.

About two-thirds of COP and all waiver participants received care in their own homes or apartments; only 15 percent were living in community-based residential facilities (CBRF). A majority of the participants also had family or friends involved in providing voluntary care. Quality assurance reviews measured high rates of consumer satisfaction, especially for people living in their own homes.

In 2000, Family Care (a comprehensive long-term care benefit) began in five Wisconsin counties. Consequently, in 2003 there was a decline in the numbers of COP, COP-W and CIP II participants in those counties as participants transferred into the Family Care program, and COP-W and CIP II ceased to exist in those counties.

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INTRODUCTION

This report is submitted pursuant to s. 46.27(11g) and s. 46.277(5m), of the Wisconsin Statutes, which requires summary reporting on state funds appropriated in the biennial budget process for the Community Options Program. The Community Options Program (also known as COP-Regular or Classic COP) serves all client groups in need of long-term care and is entirely state-funded.

The statutes also permit COP funds to be used with the flexibility to expand Medicaid waiver programs. The federal government grants waivers of Medicaid rules to permit states to provide long-term care at home to a population that qualifies for Medicaid coverage of nursing home care. State funds are matched by federal Medicaid dollars at a ratio of about 40:60. The Community Options Program-Waiver (COP-W) is limited to persons who are elderly and/or persons with a physical disability. The federal Community Options Program-Waiver also includes the Community Integration Program II (CIP II). (See Appendix B.)

Other Medicaid waiver programs are targeted to specific populations in need of long-term care services. Community Integration Program 1A (CIP 1A), Community Integration Program 1B (CIP 1B) and Community Supportive Living Arrangements (CSLA) all serve the community needs for long-term care participants with developmental disabilities. Brain Injury Waiver (BIW) serves individuals who have received brain injury rehabilitation. The Community Options Program state funding is often used as match for federal funds through these waivers.

This report describes the persons served, program expenditures and services delivered primarily through COP, COP-W and CIP II in CY 2003. Information on all waivers has been reported where data was available. Medicaid waiver funding combined with Medicaid card funded services (acute care) and COP provides a comprehensive health care package to recipients. It is critical that these programs be closely coordinated in order to ensure that the most comprehensive and individualized care is provided. With this kind of coordination, Wisconsin residents are provided with a safe, consumer-controlled alternative to life in an institution. As this report demonstrates, these programs also help contain the costs of providing long-term care to a fragile population.

STRUCTURE

The Department of Health and Family Services administers COP and COP-W while the programs are managed by county agencies. Funds are allocated to counties based on the Community Aids formula (base allocation) or for special needs, such as nursing home relocations or to address waiting lists.

The success of the Community Options Program is measured both by how well the program is able to help contain the use and cost of Medicaid-funded nursing home care, and by producing positive outcomes for the program participants. Both COP and COP-W together provide complementary funding to enable the arrangement of comprehensive services for people in their own homes based on the values of consumer direction and preference. The coordination of county resources is outlined in the local Community Options Program Plan, a description of the county policies and practices, which assures the prudent, cost-effective operation of the Community Options Program. Each county COP plan is updated annually with approval by the local Long-Term Support Planning Committee.

State level program management monitors local compliance with statutory program requirements, including:

- significant proportions;
- allowable residential settings;
- county COP plan approval; and
- the mandated use of federally-funded home and community-based Medicaid waivers prior to using state-funded COP.

PARTICIPANTS SERVED BY PROGRAMS

The following table provides information about the numbers of participants in various waiver programs. The Community Options Program, in combination with Medicaid waiver funds, is used to support individuals in the community. The program category column in Table 1 lists each funding source by type of Medicaid waiver, and when each waiver is combined with COP funding. (See Appendix B for definitions of community long-term care programs.) The categories of participants are elderly, persons with physical disabilities (PD), persons with developmental disabilities (DD), persons with severe mental illness (SMI), and persons with alcohol and/or drug abuse (AODA).

TABLE 1

Participants Served by Programs During 2003 with COP and all Waivers

Program Category	Elderly	PD	DD	SMI	AODA	Other	Medicaid Waiver Funds Only	Waiver w/Additional COP	Total Served Unduplicated
COP-W									9,003
Waiver Only	4,426	1,595					6,021		
Waiver/COP	2,370	612						2,982	
CIP II									3,640
Waiver Only	1,042	1,411					2,453		
Waiver/COP	643	544						1,187	
Sub Total COP-W/CIP II	8,481	4,162					8,474	4,169	12,643
CIP 1A									1,156
Waiver Only	43		1,052				1,095		
Waiver/COP	3		58					61	
CIP 1B Regular									2,888
Waiver Only	180		2,566				2,746		
Waiver/COP	15		127					142	
CIP 1B/CSLA COP Match									2,507
Waiver/COP for match only	90		2,126				2,216		
COP match waiver w/other COP	16		275					291	
CIP 1B/CSLA Other Match									4,228
Waiver/other for match	167		3,966				4,133		
Waiver/COP	9		86					95	
Brain Injury Waiver									225
Waiver Only	0	137	68				205		
Waiver/COP	0	16	4					20	
Brain Injury COP Match									7
Waiver/COP for match only	0	4	2				6		
COP match waiver w/other COP	0	1	0					1	
Brain Injury Waiver Other Match									70
Waiver/other for match	0	35	31				66		
Waiver/COP	0	2	2					4	
Sub Total Developmental Disabilities Waivers	523	195	10,363				10,467	614	11,081
COP Only Participants	347	140	116	854	10	3			1,470
Totals by Target Population	9,351	4,497	10,479	854	10	3	18,941	4,783	TOTAL 25,194
% Served by Target Population	37.1%	17.8%	41.6%	3.4%	0.04%	0.01%	75.2%	19.0%	

NOTE: Participants with a dual diagnosis are counted under the funding program. Source: 2003 HSRS.

- Total unduplicated participants served in 2003 - 25,194.
- Total participants who were served by a Medicaid waiver only (no COP funds) - 18,941.
- Total Medicaid waiver participants who also received COP funding in CY 2003 - 4,783.
- Total participants who received only COP funding (not Medicaid eligible) - 1,470.
- All participants who received either pure COP or COP to supplement waiver funds - 6,253.
- Total participants served with COP and COP-W funds - 14,496.

PARTICIPANTS SERVED BY TARGET GROUP

The Community Options Program and all the home and community-based waivers combined served a total of 25,194 persons. The table below illustrates participants served in 2003 with COP and Medicaid waiver funding by target group.

TABLE 2
Participants Served by Target Group During 2003 with COP and All Waivers

Target Group	COP Only	COP-W	Subtotal COP Only, COP-W	All Other COP Used as Match	CIP II	Subtotal COP Only, COP-W, Other COP, CIP II	CIP 1, CSLA, BIW	GRAND TOTAL
Elderly	347 23.6%	6,796 75.5%	7,143 68.2%	133 4.7%	1,685 46.3%	8,961 52.9%	390 4.7%	9,351 37.1%
PD	140 9.5%	2,207 24.5%	2,347 22.4%	23 0.8%	1,955 53.7%	4,325 25.5%	172 2.1%	4,497 17.8%
DD	116 7.9%	0 0%	116 1.1%	2,680 94.5%	0 0%	2,796 16.5%	7,683 93.2%	10,479 41.6%
SMI	854 58.1%	0 0%	854 8.2%	0 0%	0 0%	854 5.0%	0 0%	854 3.4%
AODA	10 0.7%	0 0%	10 0.1%	0 0%	0 0%	10 0.1%	0 0%	10 0.04%
Other	3 0.2%	0 0%	3 0.0%	0 0%	0 0%	3 0.0%	0 0%	3 0.01%
Total	1,470 5.8%	9,003 35.7%	10,473 41.6%	2,836 11%	3,640 14.4%	16,949 67.3%	8,245 32.7%	25,194 100.0%

Note: Totals may not equal 100% due to rounding. Source: 2003 HSRS.

- 9,351 or 37% were elderly;
- 4,497 or 18% were persons with physical disabilities (PD);
- 10,479 or 42% were persons with developmental disabilities (DD);
- 854 or 3% were persons with severe mental illness (SMI); and
- 13 or less than 1% were persons with alcohol and/or drug abuse (AODA) or other conditions.

FIGURE 1
Participants Served by Target Group During 2003 with COP and All Waivers

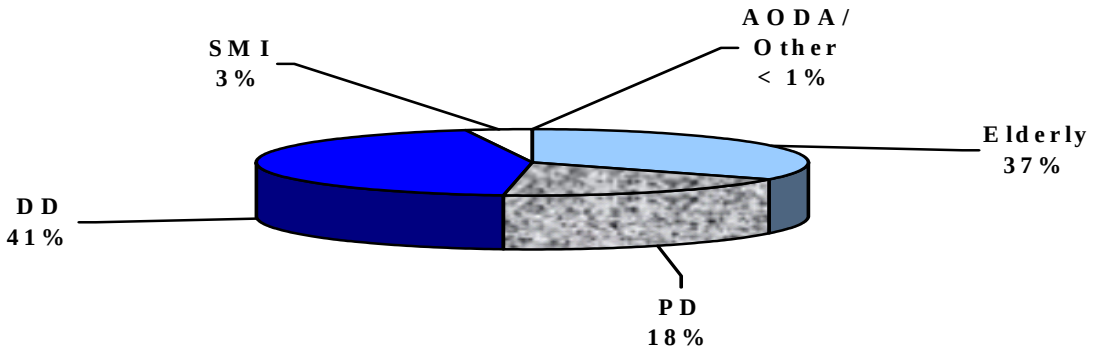
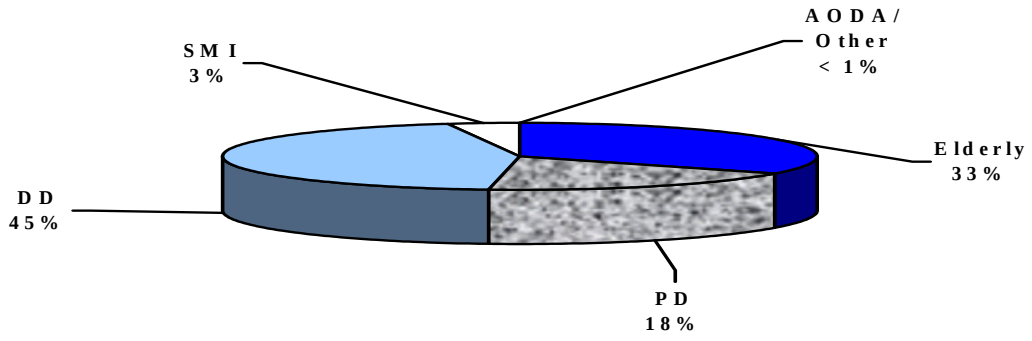


TABLE 3
Participants Served by Programs on December 31, 2003 (Point-In-Time) with COP and All Waivers

Program Category	Elderly	PD	DD	SMI	AODA	Other	Medicaid Waiver Funds Only	Waiver w/Additional COP	Total Served Unduplicated
COP-W									7,312
Waiver Only	3,898	1,480					5,378		
Waiver/COP	1,485	449						1,934	
CIP II									3,099
Waiver Only	912	1,374					2,286		
Waiver/COP	416	397						813	
Sub Total COP-W/CIP II	6,711	3,700					7,664	2,747	10,411
CIP 1A									1,111
Waiver Only	39		1,024				1,063		
Waiver/COP	3		45					48	
CIP 1B Regular									2,805
Waiver Only	176		2,521				2,697		
Waiver/COP	7		101					108	
CIP 1B/CSLA COP Match									2,391
Waiver/COP for match only	86		2,058				2,144		
COP match waiver w/other COP	13		234					247	
CIP 1B/CSLA Other Match									4,133
Waiver/other for match	160		3,896				4,056		
Waiver/COP	9		68					77	
Brain Injury Waiver									222
Waiver Only	1	134	68				203		
Waiver/COP	0	16	3					19	
Brain Injury COP Match									7
Waiver/COP for match only	0	4	2				6		
COP match waiver w/other COP	0	1	0					1	
Brain Injury Waiver Other Match									69
Waiver/other for match	0	36	30				66		
Waiver/COP	0	1	2					3	
Sub Total Developmental Disabilities Waivers	494	192	10,052				10,235	503	10,738
COP Only Participants	246	121	92	747	7	1			1,214
Totals by Target Population	7,451	4,013	10,144	747	7	1	17,899	3,250	TOTAL 22,363
% Served by Target Population	33.3%	17.9%	45.4%	3.3%	0.03%	0.00%	80.0%	14.5%	

NOTE: Participants with a dual diagnosis are counted under the funding program. Source: 2003 HSRS.

FIGURE 2 - Point-in-Time Participants Served by Target Group with COP and All Waivers on 12/31/03



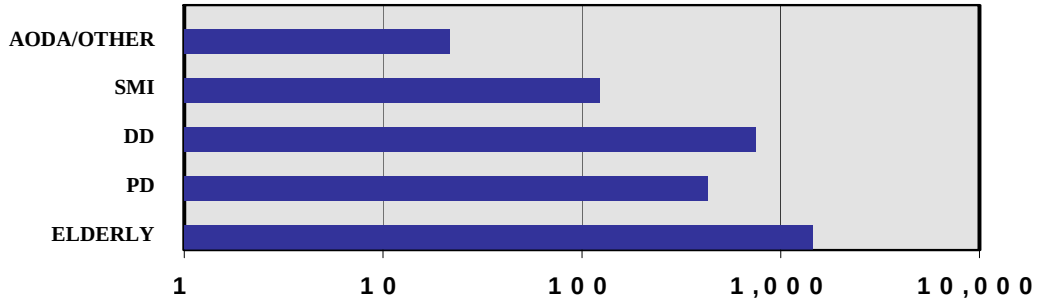
ASSESSMENTS, CARE PLANS AND PERSONS SERVED

The Community Options Program lead agencies provide eligible individuals with an assessment and care plan that identifies equipment, home modifications and services that might be available to assist them in their own homes and communities. During the assessment process, a social worker and other appropriate professionals assess each individual's unique characteristics, medical condition, living environment, lifestyle preferences and choices. The individual and the care manager develop a plan for a comprehensive package of services, which integrates and supports the informal and unpaid assistance available from family and friends. This care plan incorporates individual choices and preferences for the type and arrangement of services. Depending upon available income and assets, the individual may be responsible for paying some or all of the costs for services in their care plan. In 2003, 7,952 assessments were conducted, and 5,137 care plans were prepared.

NEW PERSONS

Figure 3 illustrates the target group distribution of the 3,629 new persons served during 2003. The majority of the new participants served in 2003 were elderly. Clients are considered new if they have services and costs in the current year and no long-term support services of any type in the prior year.

FIGURE 3
New Persons Receiving Services by Target Group in 2003



For COP and All Waivers

AODA/Other	SMI	DD	PD	Elderly
31 (0.9%)	135 (3.7%)	883 (24.3%)	662 (18.2%)	1,918 (52.9%)

Source: 2003 HSRS.

PARTICIPANT CASE CLOSURES

Table 4 illustrates the number of participants in each target group who left the program in 2003 for various reasons. Approximately 11 percent of all participants' cases were closed during 2003. About 44 percent of elderly case closures and 38 percent of closures of persons with physical disabilities were due to death. Approximately 34 percent of all cases that were closed were due to moving to an institution. Of the elderly cases closed, 42 percent were due to moving to an institution.

TABLE 4
Reasons for Participant Case Closures for COP and All Waivers

	Elderly	PD	DD	SMI	AODA	Other	Total
Person Died	843	176	83	14	1	0	1,117
Moved to Hospital/Nursing Facility or Other Institution	807	67	42	12	1	2	931
Transferred to Partnership Program	11	4	3	1	0	0	19
No Longer Income or Care Level Eligible	61	35	6	9	0	0	111
Voluntarily Ended Services	84	58	37	52	2	3	236
Moved	92	117	74	17	0	0	300
Other	7	1	10	4	0	0	22
Total Cases Closed (all reasons)	1,905	458	255	109	4	5	2,736

Source: 2003 HSRS.

PARTICIPANT TURNOVER RATE

The Community Options Program participants receive services as long as they remain eligible and continue to need services. In the past, two-thirds of COP and COP-W participants received services for three years or less. The other one-third of program participants are longer-term participants who received services for as long as ten years.

Turnover is defined as the number of new participants who need to be added in order to keep the caseload constant. For example, a local program may need to serve 125 persons during a year to maintain an average ongoing caseload of 100, and would have had a turnover of 25 participants. The turnover rate equals the amount of turnover divided by the total caseload. In this example, the turnover rate is 25 percent.

Table 5 illustrates the number of cases closed during 2003 divided by the caseload size on December 31, 2002 for each target group. The shaded row of Table 5 below shows the turnover rate for each target group. (The "other" category reflects reporting errors which are corrected by January 1, 2004.)

TABLE 5
Calculation of Turnover by Target Group for COP and All Waivers

	Elderly	PD	DD	SMI	AODA	Other	Total
All Persons Served During 2003	9,351	4,497	10,479	854	10	3	25,194
Point-in-Time Number of Persons Served on December 31, 2003	7,451	4,013	10,144	747	7	1	22,363
Number of Cases Closed During 2003 (Excludes Transfers to the Family Care Program)	1,905	458	255	109	4	5	2,736
Point-in-Time Number of Persons active on December 31, 2002 (Caseload Size)	7,285	3,896	9,655	819	8	1	21,664
Turnover Rate for the Above Case Closures	26%	12%	3%	13%	50%	n/a	13%

Source: 2003 HSRS.

COP FUNDING FOR EXCEPTIONAL NEEDS

Within the statewide Community Options Program a fund exists for exceptional needs. The Department may carry forward to the next fiscal year any COP and COP-W GPR funds allocated but not spent by December 31 (s. 46.27(7)(g), Wis. Stats.). These exceptional funds are made available to applicant counties for the improvement or expansion of long-term community support services for clients. Services may include:

a) start-up costs for developing needed services for eligible target groups;

b) home modifications for COP eligible participants and housing funding;

c) purchase of medical services and medical equipment or other specially adapted equipment; and

d) vehicle modifications.

In 2003, funds for exceptional needs were awarded to 43 counties. For example, individual awards include "homecoming" funds that allow people to purchase or pay for household furnishings, equipment, security deposits and other items to enable them to move from an institution into the community. Awards were made for home repairs and modifications such as ramps, mobility lifts, overhead track lifts, roll-in showers, raised toilets, lowered cabinets and fixtures, grab bars, wider hallways and doors, door openers, automatic controls for windows, lights, temperature devices, adapted beds, adapted chairs and other items. Awards were also made for adapted mobility equipment such as wheelchairs, walkers and scooters not covered by Medicaid, as well as van modifications.

NURSING HOME RELOCATIONS

In 2003, county long-term support agencies in 59 counties relocated 266 people from general nursing homes to community-based settings using funding from the COP-Waiver and CIP II programs. Under current law, the number of relocations are dependent on the availability of ongoing waiver or specially designated relocation funds, program turnover and the person's place on the waiting list.

TABLE 6A
Number of Relocated Participants by Age Group

AGE GROUPS	18-34	35-54	55-64	65-74	75-89	90+	TOTAL
NUMBER OF PARTICIPANTS	12	33	36	63	105	17	266

Source: 2003 HSRS

TABLE 6B
COP-W/CIP II Relocated Participants by Type of Residence

TYPE OF RESIDENCE	Adult Family Home	Brain Injury Rehab Unit	CBRF	Own Home or Apartment	RCAC	TOTAL
NUMBER OF PARTICIPANTS	22	1	84	153	6	266
PERCENTAGE	8%	0.4%	32%	58%	2%	100%

NOTE: Some totals may not equal 100% due to rounding. Source: 2003 HSRS

An additional 18 individuals were able to relocate with the assistance of one-time funding made available through a federal grant known as the Homecoming II project. This funding enabled individuals to set up their living arrangement; however, they were able to have their ongoing needs met by Medicaid or their own health insurance or income and did not need to rely on waiver funding.

SIGNIFICANT PROPORTIONS AND TARGET GROUPS SERVED WITH COP AND COP-W FUNDS

The COP and COP-W funding is intended to serve persons in need of long-term support at an institutional level of care. State statutes require that COP funding serve persons from the major target groups in proportions that approximate the percentages of Medicaid-eligible persons who are served in nursing homes or state institutions. These percentages are called "significant proportions."

The minimum percentages for significant proportions were initially set in 1984 and have been periodically adjusted to reflect changes in the growth of the long-term care population. The percentage for elderly has been set lower than the actual population to allow some county flexibility. The total minimum percentages add up to 84.2 percent with 15.8 percent reserved for county discretion.

TABLE 7A
Detail of 2003 Significant Proportions by Target Groups

2003

	Elderly	PD	DD	SMI	AODA	Other	Total
Total served excluding the Partnership Program and Milwaukee County Disability Services[1]	6,189	1,808	2,469	755	22	30	11,273
Percentage for above total	54.9%	16.0%	21.9%	6.7%	0.2%	0.3%	100%
Partnership Program participants served[2]	803	556	0	0	0	0	1,359
Total including the Partnership Program participants	6,992	2,364	2,469	755	22	30	12,632
Percentage for above total	55.4%	18.7%	19.5%	6.0%	0.2%	0.2%	100%
Participants served by Milwaukee County Disability Services[3]	11	497	858	126	1	0	1,493
Standard Methodology (including the above participants)[4]	7,003	2,861	3,327	881	23	30	14,125
Percentage for above total	49.6%	20.3%	23.6%	6.2%	0.2%	0.2%	100.0%

Source: 2003 HSRS, Reconciliation Schedules, and Partnership Enrollment Data.

TABLE 7B
Individuals and Percentages Used for Monitoring Significant Proportions 2000 - 2003

2000 - 2003

Year	Elderly	PD	DD	SMI	AODA	Other	Total
2003[4]	7,003 49.6%	2,861 20.3%	3,327 23.6%	881 6.2%	23 0.2%	30 0.2%	14,125[4] 100%
2002[4]	6,738 48.8%	2,911 21.1%	3,338 24.2%	819 5.9%	8 0.1%	1 0.0%	13,815[4] 100%
2001	6,430 50.9%	2,035 16.1%	3,106 24.6%	967 7.7%	29 0.2%	68 0.5%	12,635 100%
2000	7,972 56.1%	2,062 14.5%	3,155 22.2%	993 7.0%	23 0.2%	0 0%	14,205 100%
Minimum Percentages	57.0%	6.6%	14.0%	6.6%	0%		

Note: Counts reflect individuals served with COP and COP-W funding on December 31st of each year with adjustments applied.
Source: 2003 HSRS, Reconciliation Schedules, and Partnership Enrollment Data.

1. These numbers include calculation for COP funding used as overmatch and for county specific variances. They do not include individuals served by Milwaukee County Disability Services or those served by the Partnership Program who count for significant proportions.
2. Numbers of individuals served by the Partnership Program in Chippewa, Dane, Dunn, Eau Claire and Milwaukee County Disability Services who are counted for significant proportions.
3. Numbers of individuals served by Milwaukee County Disability Services with COP and COP-W funding.
4. Unduplicated count of individuals whose services are funded with COP Regular, COP-W or CIP IB when COP funding is used to provide the local match. The numbers include a calculation adjustment to factor in the amount of COP funding that is used as match for services above the CIP I and CIP II rate. (This methodology counts approximately one additional person for every $10,000 of COP regular funds used in this way.) Totals include adjustments for county specific variances and persons served by the Partnership Program and Milwaukee County Disability Services.

PARTICIPANT DEMOGRAPHIC AND SERVICE PROFILES

TABLE 8 - COP and All Waiver Participants Served in 2003

PARTICIPANTS SERVED IN 2003	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
COP Only	347	140	116	854	13	1,470	6%
COP-W	6,796	2,207	0	0	0	9,003	36%
All Other COP Used as Match	133	23	2,680	0	0	2,836	11%
CIP II	1,685	1,955	0	0	0	3,640	14%
CIP I, CSLA and BIW	390	172	7,683	0	0	8,245	33%
TOTAL	9,351	4,497	10,479	854	13	25,194	100%

NOTE: Participants with a dual diagnosis are counted under the funding program. Some totals may not equal 100% due to rounding. Source: 2003 HSRS.

TABLE 9 - Census 2000 – Wisconsin Population by Race/Ethnic Background

WISCONSIN POPULATION IN RACE GROUPS – ALL AGES FROM CENSUS 2000	NUMBER	PERCENT
Caucasian	4,769,857	89%
African American	304,460	6%
American Indian/Native American	47,228	1%
Asian	88,763	2%
Other	153,367	3%
TOTAL	5,363,675	100%
*Hispanic/Latino (all races)	*192,921	*4%

NOTE: *The U.S. Census considers "Hispanic/Latino" an ethnicity, not a race. "Hispanic/Latino" is reported in addition to race, and is not included in the race totals or percents in this table. Some totals may not equal 100% due to rounding. SOURCE: 2000 Census.

TABLE 10 - COP and All Waiver Participants by Race/Ethnic Background

PARTICIPANTS BY RACE/ETHNIC BACKGROUND	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Caucasian	8,795	3,542	9,551	949	80	22,917	91%
African American	183	547	534	93	3	1,360	5%
Hispanic	66	72	123	6	0	267	1%
American Indian/Alaska Native	125	76	115	14	3	333	1%
Asian/Pacific Islander	180	44	73	7	1	305	1%
Unknown	3	1	7	1	0	12	.05%
TOTAL	9,352	4,282	10,403	1,070	87	25,194	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2003 HSRS.

TABLE 11 - COP and All Waiver Participants who Relocated/Diverted from Institutions

RELOCATED/DIVERTED	NUMBER	PERCENT
Diverted from Entering any Institution	21,518	85%
Relocated from General Nursing Home	1,586	6%
Relocated from ICF/MR	1,818	7%
Relocated from Brain Injury Rehab Unit	209	.83%
Other	63	.25%
TOTAL	25,194	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2003 HSRS.

TABLE 12 - COP and All Waiver Participants by Gender

PARTICIPANTS BY GENDER	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Female	7,000	2,423	4,670	567	45	14,705	58%
Male	2,352	1,859	5,733	503	42	10,489	42%
TOTAL	9,352	4,282	10,403	1,070	87	25,194	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2003 HSRS.

TABLE 13 - COP and All Waiver Participants by Age

PARTICIPANTS BY AGE	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Under 18 years	0	76	840	7	0	923	4%
18 – 64 years	0	4,206	9,563	1,063	87	14,919	59%
65 – 74 years	2,839	0	0	0	0	2,839	11%
75 – 84 years	3,540	0	0	0	0	3,540	14%
85 years and over	2,973	0	0	0	0	2,973	12%
TOTAL	9,352	4,282	10,403	1,070	87	25,194	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2003 HSRS.

TABLE 14 - COP and All Waiver Participants by Marital Status

PARTICIPANTS BY MARITAL STATUS	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Widow/Widower	4,477	210	38	21	8	4,754	19%
Never Married	1,448	1,671	10,012	724	25	13,880	55%
Married	1,957	959	138	58	20	3,132	12%
Divorced/Separated	1,335	1,360	177	243	29	3,144	12%
Other	135	82	38	24	5	284	1%
TOTAL	9,352	4,282	10,403	1,070	87	25,194	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2003 HSRS.

TABLE 15 - COP and All Waiver Participants by Natural Support Source

PARTICIPANTS BY NATURAL SUPPORT SOURCE	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Adult Child	4,548	648	24	57	18	5,295	21%
Non-Relative	1,105	818	2,064	257	12	4,256	17%
Spouse	1,518	859	82	38	16	2,513	10%
Parent	105	1,053	6,226	263	11	7,658	30%
Other Relative	1,370	545	1,205	142	15	3,277	13%
No Primary Support	705	359	793	312	14	2,183	9%
Other	1	0	9	1	1	12	.05%
TOTAL	9,352	4,282	10,403	1,070	87	25,194	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2003 HSRS.

TABLE 16 - COP and All Waiver Participants by Living Arrangement

PARTICIPANTS BY LIVING ARRANGEMENT	Elderly	PD	DD	SMI	AODA Other	Total Participants	
Living with Immediate Family	2,567	1,716	4,068	141	21	8,513	34%
Living Alone	3,566	1,122	645	398	27	5,758	23%
Living with Others with Attendant Care	1,593	449	2,950	283	24	5,299	21%
Living with Others	695	323	1,963	192	9	3,182	13%
Living Alone with Attendant Care	505	308	355	36	3	1,207	5%
Living with Immediate Family with Attendant Care	249	280	270	4	0	803	3%
Living with Extended Family	137	63	124	10	2	336	1%
Living with Extended Family with Attendant Care	27	11	15	1	0	54	.21%
Transient Housing Situation	4	8	3	3	0	18	.07%
Other	9	2	10	2	1	24	.10%
TOTAL	9,352	4,282	10,403	1,070	87	25,194	100%

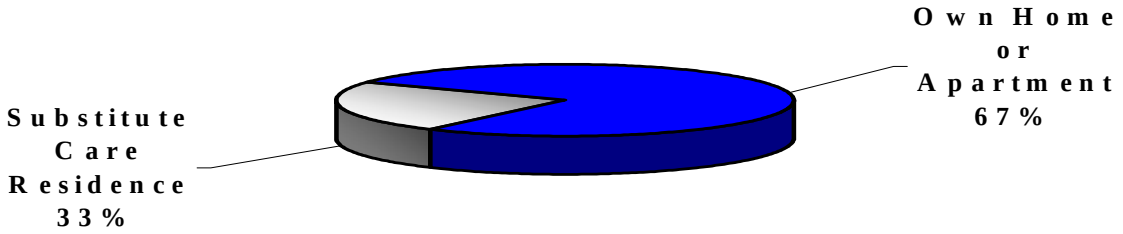
NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2003 HSRS.

TABLE 17 - COP and All Waiver Participants by Type of Residence

PARTICIPANTS BY TYPE OF RESIDENCE	Elderly	PD	DD	SMI	AODA Other	Total Participants	
Adoptive Home	0	1	80	0	0	81	.32%
Adult Family Home (AFH)	458	172	2,007	121	5	2,763	11%
Brain Injury Rehab Unit	1	11	6	0	0	18	.07%
Child Group Home	0	3	7	1	0	11	.04%
Community Based Residential Facility (CBRF)	1,572	254	1709	297	28	3,860	15%
Foster Home	57	18	317	13	2	407	2%
Nursing Home	6	0	0	0	0	6	.02%
Other Living Arrangement	2	0	1	0	0	3	.01%
Own Home or Apartment	7,011	3,757	5,419	594	51	16,832	67%
Residential Care Apartment Complex (RCAC)	145	9	0	2	0	156	.62%
Residential Care Center (RCC)	4	3	2	0	0	9	.04%
Shelter Care Facility	1	1	4	1	0	7	.03%
Supervised Community Living	95	53	851	39	0	1,038	4%
Unknown	0	0	0	2	1	3	.01%
TOTAL	9,352	4,282	10,403	1,070	87	25,194	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2003 HSRS.

FIGURE 4
Percentage of Participants Living in Own Home or Substitute Care Residence



FUNDING OF COMMUNITY LONG-TERM CARE BY TARGET GROUP

A total of $478,579,478 (federal waiver and state funds) was spent in 2003 on Community Options and all long-term care Medicaid Home and Community-Based Waivers. As a publicly-funded and managed program for community long-term care, COP-Regular contributes about 12 percent of the overall total. COP-Regular and COP-Waiver together contribute 31 percent of the overall total. [These figures do not include funds spent under the regular (non-waiver) Medicaid program.]

TABLE 18
COP and All Waivers
Funding of Community Long-Term Care by Target Group in 2003

Target Group	COP-Regular	COP-W	Subtotal COP-Regular, COP-W	CIP II	Subtotal COP-Regular, COP-W, CIP II	CIP 1, CSLA, BIW	GRAND TOTAL
Elderly	12,248,033 21%	63,884,141 72%	76,132,175 52%	22,257,152 44%	98,389,327 50%		98,389,327 21%
PD	5,983,184 10%	24,843,833 28%	30,827,017 21%	28,327,284 56%	59,154,301 30%		59,154,301 12%
DD	29,000,269 51%		29,000,269 20%		29,000,269 15%	281,866,733 100%	310,867,002 65%
SMI	9,972,694 17%		9,972,694 7%		9,972,694 5%		9,972,694 2%
AODA	127,253 0.2%		127,253 0.1%		127,253 0.1%		127,253 0.03%
Other	68,901 0.1%		68,901 0.0%		68,901 0.0%		68,901 0.01%
Total	$57,400,335 12%	$88,727,974 19%	$146,128,309 31%	$50,584,436 11%	$196,712,745 41%	$281,866,733 59%	$478,579,478 100%

Source: 2003 HSRS and Reconciliation Schedules.

- The elderly received 21% of the funds;
- Persons with physical disabilities (PD) received 12% of the funds;
- Persons with developmental disabilities (DD) received 65% of the funds;
- Persons with severe mental illness (SMI) received 2% of the funds; and
- Persons with alcohol and/or drug abuse (AODA) or other conditions received less than 1% of the funds.

FIGURE 5
Total COP and Waivers Spending by Target Group

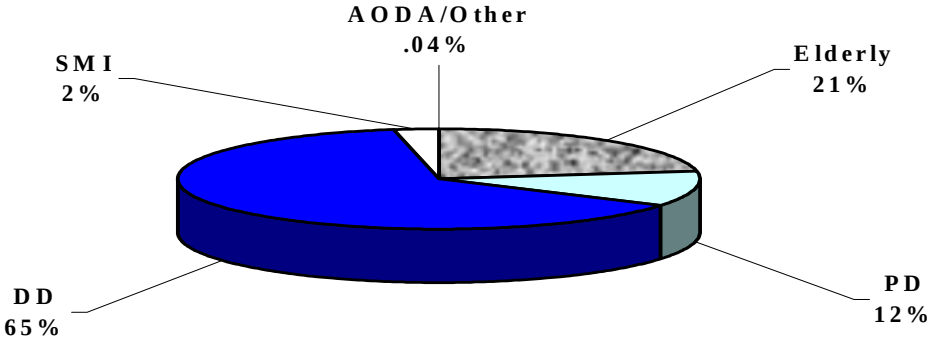
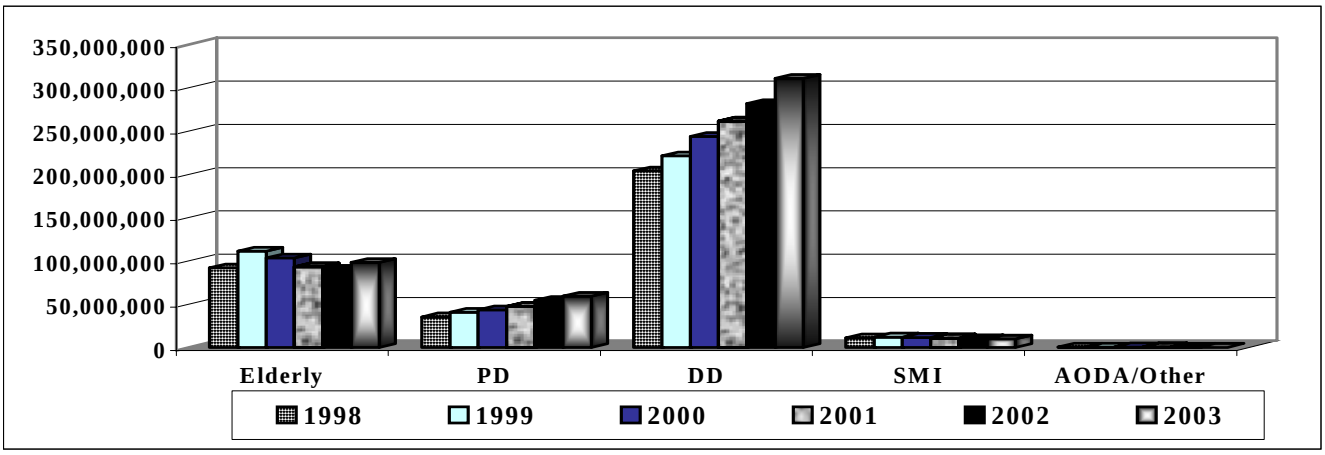


Figure 6 illustrates spending for participants by target groups. The "elderly" category includes all persons age 65 or older regardless of type of disability. All other participants are younger than 65. All participants have a need for a level of care equivalent to a nursing home care level.

FIGURE 6
Increase/Decrease in Funding for Community Long Term Care by Target Group 1998 – 2003



Note: In 2001 and 2002 COP and waiver participants converted to Family Care in five pilot counties.
Source: 2003 HSRS and Reconciliation Schedules.

HOW COP-REGULAR IS USED

Table 19 – Use of COP Regular

Target Group	COP Only	Supplemental COP (gap filling)	Additional GPR Match for Waivers	Admin, Special Projects, Risk Reserve	Assessments And Plans	Total Percent of COP-R Reported
Elderly	17.3%	55.5%	10.5%	29.7%	53.2%	21.3%
PD	7.8%	30.8%	4.4%	14.6%	25.7%	10.4%
DD	8.1%	13.7%	85.2%	21.2%	14.0%	50.5%
SMI	65.9%	0.0%	0.0%	34.0%	3.8%	17.4%
AODA/Other	0.9%	0.0%	0.0%	0.6%	3.2%	0.3%
TOTAL	22.9%	14.8%	52.7%	6.3%	3.3%	100.0%
Costs Reported*	$13,961,740	$9,022,446	$32,072,831	$3,821,372	$2,032,709	$60,911,098*

*Note: Reflects allowable costs reported on HSRS; however, actual reimbursement was $57,400,335.

- 23 percent of the total COP-Regular funds were used for services for COP only participants, 66 percent of whom are persons with a severe mental illness. There is no federal waiver available for the long-term care needs of this group.
- 15 percent of the total was used for current waiver participants to provide services that could not be paid for with waiver funds.
- 53 percent was used to create additional waiver slots and to cover the matching share of expenses for those participants whose cost of care exceeds waiver allowable rates.
- 6 percent was used for program and service coordination including one percent for special projects.
- 3 percent of COP-Regular funds were used to conduct assessments and develop care plans for COP or Medicaid waiver eligible people.

Of the funds used for additional match, $27 million was used for persons with developmental disabilities: $20 million was used as match to serve more people or for increased service costs for existing participants; $7 million was used to fund the match for CIP I so counties could earn additional federal funds when the average costs exceeded the allowable rate. When COP funding is used in this way it is referred to as "overmatch." For persons who are elderly or have physical disabilities, $4.5 million of COP-Regular funds were used as match to expand the COP-W program and $232,889 of COP-Regular funding was used as overmatch, i.e., used to fund the match for CIP II to earn additional federal dollars when average costs exceeded the allowable reimbursement rate.

PARTICIPANTS WITH ALZHEIMER'S DISEASE AND RELATED IRREVERSIBLE DEMENTIAS

In 2003, a total of 1,014 participants served in the COP, COP-W and CIP II programs were reported as having an Alzheimer's disease or related dementia diagnosis (e.g., Friedrich's Ataxia, Huntington's disease and Parkinson's disease). Of these 1,014 individuals, 12 qualified for the program by diagnosis alone. The total expenditures for participants with Alzheimer's or other irreversible dementia were $8,014,174.

MEDICAID NURSING HOME USE

The Community Options Program and the Medicaid Home and Community-Based Waivers have made possible a lower utilization of nursing home beds by Medicaid participants in Wisconsin. At the same time, COP also filled the gaps in unpaid care provided by family and friends. The extra support services paid for by COP reduce the burden on families who provide substantial amounts of unpaid care. The Community Options Program has enabled people with long-term care needs to continue to live in their own homes and communities. The Community Options Program has also been a stimulus to the growth of community care providers in the private sector. Since the beginning of COP and the development of alternatives to nursing home care, days of care paid for by Medicaid in nursing homes have declined. A portion of nursing home bed closures resulted in an additional 226 CIP II slots available in 2003.

CIP II AND COP-W SERVICES

Community Integration Program II and COP-Waiver participants utilize services federally authorized through its Medicaid waiver application and services traditionally available to all Medicaid recipients through the state's Medicaid Plan (e.g., card services). State Medicaid Plan services are provided to all Medicaid recipients eligible for a Medicaid card. The Medicaid Plan services are generally for acute medical care. Waiver services are generally non-medical in nature. Since both types of services are needed to maintain individuals in the community, expenditures for both types must be combined to determine the total public cost of serving waiver participants.

State statutes require use of Medicaid waiver funds only for expenses not covered in the Medicaid program. The waiver services provided, their utilization rate, and the total costs for each service are outlined in the table below. The total cost of Medicaid fee-for-service card costs for these waiver participants was $126,203,757.

TABLE 20
2003 Total Medicaid Costs for CIP II and COP-W Recipients

Total CIP II and COP-W Service Costs	$144,279,072
Total Medicaid Card Service Costs for CIP II and COP-W Recipients	$126,203,757
Total 2003 Medicaid Expenditures for CIP II and COP-W Recipients	$270,482,829

Source: 2003 Federal 372 Report.

Costs of care, services and environmental adaptations for waiver participants are always a combination of Medicaid State Plan benefits and waiver benefits. The coordination of benefits across the program is a key component of the Community Options Program and the waivers.

TABLE 21
2003 CIP II and COP-W Service Utilization and Costs

CIP II and COP-W Service Categories	Rate of Participant Utilization (%)	Cost	Percent of Total Waiver Costs
Care Management	99.6	$18,678,168	12.9
Supportive Home Care/Personal Care	85.6	57,159,114	39.6
Adult Family Home	4.6	9,899,037	6.9
Residential Care Apartment Complex	2.1	3,294,607	2.2
Community Based Residential Facility	19.3	35,171,608	24.4
Respite Care	4.2	1,652,288	1.2
Adult Day Care	5.5	3,066,226	2.1
Day Services	1.8	1,489,477	1.0
Daily Living Skills Training	1.5	1,731,765	1.2
Counseling and Therapies	3.6	615,362	0.4
Skilled Nursing	3.7	234,214	0.2
Transportation	24.4	2,200,039	1.5
Personal Emergency Response System	40.1	1,381,111	1.0
Adaptive Equipment	18.2	2,124,957	1.5
Communication Aids	2.2	56,930	0.0
Housing Start-up	0.0	8,047	0.0
Vocational Futures Planning	0.0	10,972	0.0
Medical Supplies	23.5	1,234,199	0.9
Home Modifications	3.8	1,396,295	1.0
Home Delivered Meals	26.4	2,874,657	2.0
Total Medicaid Waiver Service Costs		$144,279,072	

Note: Totals may not equal 100% due to rounding. Source: 2003 Federal 372 Report.

TABLE 22
2003 CIP II and COP-W Medicaid Card Service Utilization

Medicaid State Plan Benefits Categories	Rate of Participant Utilization (%)	Cost	Percent of Total Card Costs
Inpatient Hospital	4.0%	$6,440,724	5.1%
Physician (Physician Services, Clinic Services – including outpatient Mental Health)	75.4%	3,964,826	3.1%
Outpatient Hospital	54.6%	3,714,219	2.9%
Lab and X-ray	60.8%	862,129	0.7%
Prescription Drugs	96.7%	45,221,964	35.8%
Transportation (Ambulance and Non-Emergency Specialized Motor Vehicle)	48.7%	3,156,237	2.5%
Therapies (Physical Therapy, Speech and Hearing Therapy, Occupational Therapy, Restorative Care Therapy, Rehabilitative Therapy)	5.4%	327,630	0.3%
Dental Services	18.2%	514,084	0.4%
Nursing (Nurse Practitioner, Nursing Services)	0.2%	1,003,954	0.8%
Home Health, Supplies & Equipment (Home Health Therapy, Home Health Aide, Home Health Nursing, Enteral Nutrition, Disposable Supplies, Other Durable Medical Equipment, Hearing Aids)	65.3%	13,936,125	11.0%
Personal Care (Personal Care, Personal Care Supervisory Services)	33.8%	34,306,317	27.2%
All Other (Other Practitioners Services, Family Planning Services, HealthCheck/EPSDT, Rural Health Clinic Services, Home Health Private Duty Nursing – Vent, Other Care, Hospice, Community Support Program)	52.4%	12,755,547	10.1%
Total Medicaid State Plan Benefit Costs for Waiver Recipients		$126,203,757	

Notes: Totals may not equal 100% due to rounding. Source: 2003 Federal 372 Report.

PUBLIC FUNDING AND COST COMPARISON OF MEDICAID WAIVER AND MEDICAID NURSING HOME CARE

In addition to Medicaid-funded services, many waiver participants receive other public funds that can be used to help pay for long-term care costs. To provide an adequate comparison of the cost of serving persons through the Medicaid waiver versus the cost of meeting individuals' long-term support needs in nursing homes, an analysis of total public funding used by each group was completed.

Table 23 below indicates total public funds spent per capita on an average daily basis for nursing home and waiver care. It also indicates the breakdown between federal and state and/or county spending for each funding source.

TABLE 23

2003 Average Public Costs for CIP II & COP-W Participants vs. Nursing Home Residents

Average Cost per Person per Day

		Community Care Costs			Nursing Home Costs[1]			Difference		
Year	Cost Category	Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
2003	Medicaid Program Per Diem	$37.57	$14.51	$23.06	$94.96	$37.31	$57.65			
	Medicaid Card	32.86	12.91	19.95	15.48	6.08	9.40			
	Medicaid Costs Subtotal[2]	$70.43	$27.42	$43.01	$110.44	$43.39	$67.05	$40.01	$15.97	$24.04
	COP – Services w/Admin.	2.31	2.31	0.00	n/a[3]	n/a[3]	n/a[3]			
	COP – Assessments & Plans	0.42	0.42	0.00	n/a[3]	n/a[3]	n/a[3]			
	SSI	1.71	0.70	1.01	0.10	0.04	0.06			
	Community Aids	0.18	0.07	0.11	unk.	unk.	unk.			
	Other	1.98	0.82	1.16	n/a[4]	n/a[4]	n/a[4]			
	Total	$77.03	$31.74	$45.29	$110.54	$43.43	$67.11	$33.51	$11.69	$21.82

Source: 2003 HSRS and 2003 Federal 372 Report.

When all public costs are counted, expenses for CIP II and COP-W participants averaged $77.03 per person per day in 2003, compared to $110.54 per day for Medicaid recipients in nursing facilities. On average, then, the per capita daily cost of care in CIP II and COP-W during 2003 was $33.51 less than the cost of nursing home care.

TABLE 24

2003 Estimated Average Public Costs for CIP II & COP-W Participants vs. Nursing Home Residents

Adjusting for Level of Care Average Cost per Person per Day

		Community Care Costs			Nursing Home Costs*[1]			Difference		
Year	Cost Category	Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
2003	Medicaid Program Per Diem	$37.57	$14.51	$23.06	$83.56	$32.83	$50.73			
	Medicaid Card	32.86	12.91	19.95	15.48	6.08	9.40			
	Medicaid Costs Subtotal[2]	$70.43	$27.42	$43.01	$99.04	$38.91	$60.13	$28.61	$11.49	$17.12
	COP – Services w/Admin.	2.31	2.41	0.00	n/a[3]	n/a[3]	n/a[3]			
	COP – Assessments & Plans	0.42	0.42	0.00	n/a[3]	n/a[3]	n/a[3]			
	SSI	1.71	0.70	1.01	0.10	0.04	0.06			
	Community Aids	0.18	0.07	0.11	unk.	unk.	unk.			
	Other	1.98	0.82	1.16	n/a[4]	n/a[4]	n/a[4]			
	Total	$77.03	$31.74	$45.29	$99.14	$38.95	$60.19	$22.11	$7.21	$14.90

Source: 2003 HSRS and 2003 Federal 372 Report.

Assuming the same Medicaid card costs and other expenses, the average daily cost of nursing home care would have been $99.14 per person (Table 24, instead of $110.54 as reported in Table 23). The difference between average daily per capita waiver costs and average nursing home costs, therefore, would have been $22.11 instead of $33.51. This represents a difference of 22 percent, compared to 30 percent. Table 24 presents the estimated daily per capita public costs and the waiver/nursing home cost comparisons shown in Table 23 after adjusting the average nursing home per diem in this manner.

The following footnote references are for Table 23 and Table 24:

1. IMD costs are omitted from the total nursing home cost because persons who require institutionalization primarily due to a chronic mental illness are not eligible for CIP II or COP-W.
2. Medicaid reporting is subject to subsequent adjustments due to a 12-month claims processing period.
3. Nursing home residents are not eligible for the Community Options Program.
4. This category applies only to community care.

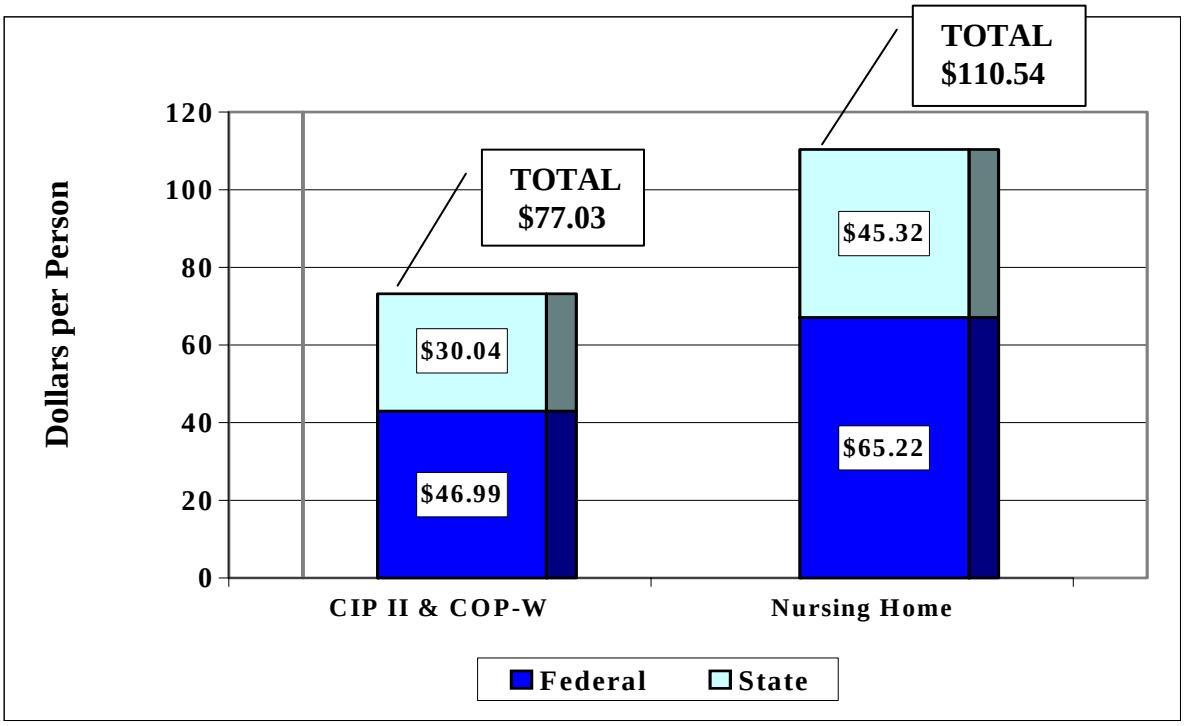
CARE LEVEL AND ITS SIGNIFICANCE FOR THE COST COMPARISONS

The cost differences evident in the previous comparisons (Table 23), while calculated using actual costs of care for waiver participants and nursing home residents, may be influenced by differences in the care needs of these two populations. In 2003, 74 percent of CIP II and COP-W participants were rated at the intermediate care facility (ICF) level and 26 percent were rated at the skilled nursing facility (SNF) level. Corresponding figures for persons residing in nursing homes during 2003 were eight percent ICF and 92 percent SNF, based on aggregate calendar year nursing home days of care. The significance of any care level difference that exists can be determined by re-estimating average daily and total public costs after adjusting the reported care level proportions.

Based on data supplied for the Department's annual cost report to the Centers for Medicare and Medicaid Services (CMS), the actual 2003 nursing home Medicaid per diem for ICF residents was approximately $79.00. For SNF residents the Medicaid per diem was approximately $96.25. If the proportions of nursing home residents receiving care at the ICF and SNF levels had been equal to the proportions reported for CIP II and COP-W participants (74 percent ICF and 26 percent SNF), estimated costs to Medicaid for nursing home care would have been $699,124,426 instead of $794,525,667. Given that there were 8,366,951 Medicaid-funded days of nursing care at the ICF and SNF levels combined in 2003, this level of total Medicaid spending would have translated to an average per diem across care levels of $83.56 (Table 24), instead of the previously calculated $94.96 (Table 23).

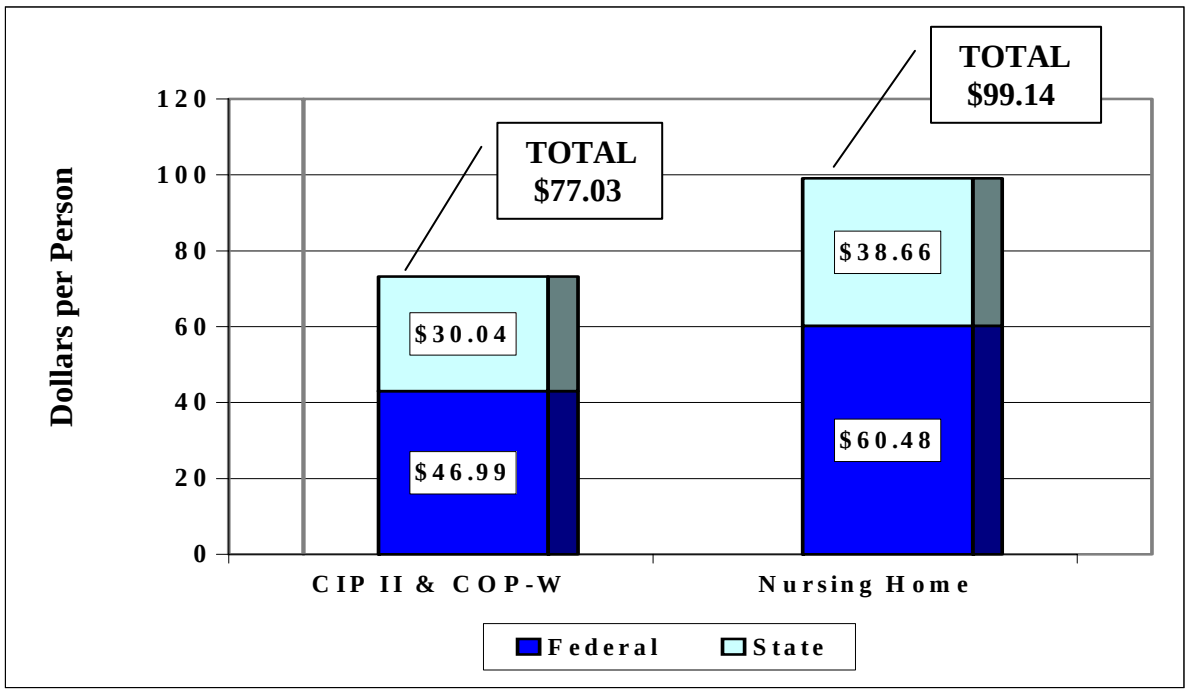
Using these adjusted figures, the potential impact of waiver utilization on total public spending can be estimated as it was in the previous section. That is, if the 12,643 waiver participants had spent the same 3,840,325 days residing in nursing homes, they would have incurred total public costs of $380,729,821 ($99.14 per day for 3,840,325 days), compared with the $295,820,235 they incurred while residing in the community. Assuming equivalent care level proportions, then, total public spending for CIP II and COP-W participants during 2003 was $84,909,586 less than the predicted cost of nursing home care for a comparable group. This figure is 11 percent less than the $424,509,526 estimated using actual 2003 data, but it still represents a difference in total public costs of 22 percent compared with the cost of an equivalent volume of nursing home care. This revised estimate may represent the lower boundary of the difference in costs attributable to these waivers, while the estimate based on actual costs represents an upper boundary.

FIGURE 7
CIP II & COP-W vs. Nursing Home Care in 2003
Average Public Costs per Day



Source: 2003 Federal 372 Report.

FIGURE 8
CIP II & COP-W vs. Nursing Home Care in 2003
Adjusting for Level of Care
Estimated Average Public Costs per Day



Source: 2003 Federal 372 Report.

Appendix A

PERFORMANCE STANDARDS

A state leadership committee established the framework for assessing quality in the Community Options Program (COP). In order to ensure the goals of COP are met, person-centered performance outcomes valued by COP participants are incorporated into the acronym RESPECT:

Relationships between participants, care managers and providers are based on caring, respect, continuity over time, and a sense of partnership.

Empowerment of individuals to make choices, the foundation of ethical home and community-based long-term support services, is supported.

Services that are easy to access and delivered promptly, tailored to meet unique individual circumstances and needs are provided.

Physical and mental health services are delivered in a manner that helps people achieve their optimal level of health and functioning.

Enhancement and maintenance of each participant's sense of self-worth, and community recognition of his or her value is fostered.

Community and family participation is respected and participants are supported to maintain and develop friendships and share in their families and communities.

Tools for self-determination are provided to help participants achieve maximum self-sufficiency and independence.

RESPECT performance standards are measured by the extent to which:

- care managers identify a participant's health status and care needs, create or arrange for appropriate services to support and not supplant the help available from family, friends and the community, and monitor the performance of service providers;
- services respond to individual needs;
- participant preferences and choices are honored, and the participant is satisfied with the services delivered; and most importantly,
- participants are able to maintain a home of their own choice and participate in community life.

Appendix B

DEFINITIONS OF COMMUNITY LONG-TERM CARE PROGRAMS

COMMUNITY OPTIONS PROGRAM (COP):
The Community Options Program, administered by the Department of Health and Family Services, is managed by local county agencies to deliver community-based services to Wisconsin citizens in need of long-term assistance. Any person, regardless of age, with nursing home level of care is eligible for COP. The program began as a demonstration in eight counties in 1982 and was expanded statewide in 1986.

Funding: GPR/State = 100%.

COMMUNITY OPTIONS PROGRAM-WAIVER (COP-WAIVER OR COP-W):
A Medicaid-funded waiver program which provides community services to the elderly and persons with physical disabilities who have long-term needs and who would otherwise be eligible for Medicaid reimbursement in a nursing home.

Funding: GPR/State = Approximately 40% (budgeted separately with COP GPR/state funds)
Federal = Approximately 60%

COMMUNITY INTEGRATION PROGRAM II (CIP II):
A Medicaid-funded waiver program that provides community services to the elderly and persons with physical disabilities *after a nursing home bed is closed.*

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

COMMUNITY INTEGRATION PROGRAM IA (CIP IA):
A Medicaid-funded waiver program that provides community services to persons with developmental disabilities who are relocated from the State Centers for the Developmentally Disabled.

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

COMMUNITY INTEGRATION PROGRAM IB REGULAR (CIP IB):
A Medicaid-funded waiver program which provides community services to persons with developmental disabilities who are relocated or diverted from nursing homes and Intermediate Care Facilities – Mental Retardation (ICFs-MR) other than the State Centers for the Developmentally Disabled.

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

COMMUNITY INTEGRATION PROGRAM IB (CIP IB)/LOCAL MATCH:
A Medicaid-funded waiver program which provides community services to persons with developmental disabilities who are relocated or diverted from nursing homes and ICFs-MR other than the State Centers for the Developmentally Disabled.

Funding: GPR/State = Approximately 40% (Community Aids, county match, or COP funds)
Federal = Approximately 60% (federal Medicaid funding)

COMMUNITY SUPPORTED LIVING ARRANGEMENTS (CSLA-WAIVER):
A Medicaid-funded waiver program that serves the same target group as CIP IB. CSLA provides funds that enable individuals to be supported in their own homes. The program began as a demonstration in some counties in 1992 and was expanded statewide January 1, 1996.

Funding: GPR/State = Approximately 40% (Community Aids, county match, or COP funds)
Federal = Approximately 60% (federal Medicaid funding)

BRAIN INJURY WAIVER:
A Medicaid-funded waiver that serves a limited number of people with brain injuries who need significant supports in the community. The person must be receiving or is eligible to receive post-acute rehabilitation services in a nursing home or hospital certified by Wisconsin Medicaid as a special unit for brain injury rehabilitation. This program began January 1, 1995.

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

Appendix C

QUALITY ASSURANCE AND IMPROVEMENT OUTCOMES

Wisconsin has implemented a plan to demonstrate and document quality assurance efforts, which will ensure the health, safety and welfare of community waiver program participants. The quality assurance and improvement program combines a number of activities to assess and monitor program integrity, customer safety, customer satisfaction and program quality. The information obtained is provided as feedback to local and state agencies to promote quality improvement.

PROGRAM INTEGRITY

On-site monitoring reviews were conducted for a random selection of 435 cases in 2003. The reviews went well beyond the traditional federal requirements, which only identify payment errors, in an effort to gain in-depth information on program operation and policy interpretation. Where errors were identified, corrective action plans were implemented. For all criteria monitored, 91 percent compliance with the waiver requirements was verified. A summary of the monitoring categories and findings are as follows:

Category: FINANCIAL ELIGIBILITY

Monitoring Components:
- ✓ *Medicaid financial eligibility as approved in state plan*
- ✓ *Cost share*
- ✓ *Spend down*

Findings: 96 *percent of the factors monitored indicated no deficiency. Errors were detected in more complex areas of calculation, such as cost share and spend down. These areas have been emphasized in training and technical assistance activities. A disallowance occurred if the cost share was included in the expenses billed to the waiver.*

Category: NON-FINANCIAL ELIGIBILITY

Monitoring Components:
- ✓ *Health form*
- ✓ *Functional screen*

Findings: 98 *percent overall compliance with eligibility was measured. No instances of incorrect eligibility determination were identified under this category, although some cases failed to contain sufficient documentation.*

Category: SERVICE PLAN

Monitoring Components:
- ✓ *Individual Service Plan (ISP) developed and reviewed with participant*
- ✓ *Services waiver allowable*
- ✓ *Services appropriately billed*

Findings: 88 *percent of factors were in compliance. In a small percentage of the cases, incorrectly identified services or the omission of identified services within the ISP was noted. Only the inclusion of non-allowable costs resulted in negative findings and a disallowance of state/federal funding.*

Category: SERVICE STANDARDS AND REQUIREMENTS

Monitoring Components:
- ✓ *Waiver-billed services met necessary standards and identified needs*
- ✓ *Care providers appropriately trained and certified*

Findings: 86 *percent of factors were documented as error free. Documentation deficits accounted for many of the negative findings under this category. Disallowances were taken if standards had not been met.*

Category: BILLING

Monitoring Components:
- ✓ *Services accurately billed*
- ✓ *Only waiver allowable providers billed*
- ✓ *Residence in waiver allowable settings during billing period*

Findings: 90 *percent compliance was found in these categories. A process has been implemented to assist in improving billing accuracy which may account for the eight percent improvement over last year. Disallowances were taken.*

Category: SUBSTITUTE CARE

Monitoring Components:
- ✓ *Contracting requirements have been met*
- ✓ *Only waiver allowable costs calculated and billed*

Findings: 96 *percent overall compliance was found. Documentation or errors due to room and board versus care and supervision were evidenced in a few cases. Residential care has proven to be a challenging area for services providers and is being addressed with technical assistance and training. Disallowances were taken.*

CORRECTIVE ACTION

A written report of each monitoring review was provided to the director of the local agency responsible for implementing the waiver participant's service plan. The reports cited any errors or deficiencies and required that the deficiency be corrected within a specified period of time, between one and 90 days. Follow-up visits were conducted to ensure compliance when written documentation was insufficient to provide assurance. Where a deficiency correlated with ineligibility, agencies were instructed to correct their reimbursement requests. All agencies complied by modifying their practices and acknowledging the deficiencies.

In 2003, a total of 36 agencies were monitored. In 22 instances, disallowances were taken from counties where retroactive corrections could not be implemented. The total disallowance for the 22 agencies combined was $86,406. Disallowances were taken in areas including billing of non-allowable services, data entry errors, lack of documentation for billed services, billing during a period of ineligibility for waiver services, and inaccurate collection of cost share.

PROGRAM QUALITY

During 2003, 435 randomly selected participants responded to 22 questions during in-person interviews regarding satisfaction with waiver services. Both direct responses and reviewer assessments of those responses were recorded.

The factors studied regarding care management services were:

- ❑ Responsiveness to consumer preferences
- ❑ Quality of communication
- ❑ Level of understanding of consumer's situation
- ❑ Professional effectiveness
- ❑ Knowledge of resources
- ❑ Timeliness of response

The factors studied for in-home care were:

- ❑ Timeliness
- ❑ Dependability
- ❑ Responsiveness to consumer preferences

The factors studied for persons living in substitute care settings were:

- ❑ Responsiveness to consumer preferences
- ❑ Choices for daily activities
- ❑ Ability to talk with staff about concerns
- ❑ Comfort

Table 25 combines and summarizes the findings of the survey. Satisfaction in substitute (residential) care settings is somewhat lower than satisfaction with services in one's own home.

Table 25
Program Quality Results

SATISFACTION CATEGORY	PERCENTAGE OF POSITIVE RESPONSES
Care manager is effective in securing services	93%
Good communication with care manager	94%
Care manager is responsive	91%
Active participation in care plan	90%
Satisfaction with in-home workers	92%
Substitute care services are acceptable	85%
Satisfaction with substitute care living arrangement	86%

Source: 2003 Quality Monitoring Reviews.

CONTINUOUS QUALITY IMPROVEMENT PROJECTS

The information collected from various quality assurance efforts was incorporated into a variety of ongoing quality improvement projects. Examples of those activities are listed below:

- Provide issue specific or county specific intensive monitoring or training where significant errors have been identified. Repeat monitoring where necessary.
- Develop issue specific technical assistance documents. Quarterly, this includes answers to the most frequently asked questions. The document entitled "WaiverWise" is now available on the Department of Health and Family Services website.
- Conduct statewide training in the areas of Fiscal Management, Eligibility, Service Standards, Advanced Care Manager/Economic Support Training, Care Management Techniques, and Service Plan Development.
- Utilize enhanced data collection and reporting formats to identify target areas for monitoring and technical assistance.
- Produce and distribute case specific fiscal reports containing potentially correctable reporting errors.
- Conduct enhanced interviews to determine customer satisfaction.
- Transition responsibility to county agencies for quality assurance of the annual recertification of participant eligibility.

We gratefully acknowledge the efforts of County Community Options Program Lead Agencies to report COP and waiver activities and expenditures completely and accurately, since this information is the foundation for the data compiled in this report. Questions may be directed to:

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